

FEB 27 1940

U. S. No. 2
M-11-10-39
Rev. 5-17-39
I X21492DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

8059

Registration District No.

784

Primary Registration District No.

101

Registrar's No.

401

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town Clayton
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis County Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 day
 In this community 15 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Marion Meier

600

3. (b) If veteran,
name war

?

3. (c) Social Security
No.

?

4. Sex female5. Color or
race white6. (a) Single, widowed, married,
divorced married6. (b) Name of husband or wife
Anthony Meier6. (c) Age of husband or wife if
alive ? years

7. Birth date of deceased

9

6

1883

(Month)

(Day)

(Year)

8. AGE:

Years
56Months
5Days
19

If less than one day

hr. min.

9. Birthplace

Unk. Wauscha Wis.
(City, town, or county) (State or foreign country)

10. Usual occupation

housewife

11. Industry or business

12. Name Unk.13. Birthplace Unk.

(City, town, or county)

Unk.

(State or foreign country)

14. Maiden name Unk.15. Birthplace Unk.

(City, town, or county)

Unk.

(State or foreign country)

16. (a) Informant Anthony J Meier(b) Address 735 Apian Ave

17. (a)

(Burial, cremation, or removal)

(b) Date thereof Feb 28 - 40

(Month) (Day) (Year)

(c) Place: burial or cremation National Cem18. (a) Signature of funeral director C. H. Hoffmeister URB.(b) Address 7214 S. Bigelow Ave

19. (a)

(Date received local registrar)

(b) R. Meyer M.D. & Co.

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis
 (c) City or town Lemay
 (If outside city or town limits, write "RURAL")
 (d) Street No. 435 Apian dr. (Kingston Pk.)
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 25
 year 1940 hour 3 minute 15 P. M.

21. I hereby certify that I attended the deceased from 2-24-40
 19 to 2-25-40 19;
 that I last saw her alive on 2-25-40 19;
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral accident Duration 3 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy not reported yet

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
 (b) Date of occurrence
 (c) Where did injury occur? (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

(M. D. or other)

Address St. Louis, Mo. C. Hoffmeister Date signed

(Licensed Embalmers' Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEC 27 1956

MAR 1 1957

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Registered Apprentice No. _____ working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.